EHR in Private Medical Practice Teleconference Meeting Minutes
Monday, August 8, 2005 (2PM – 3:30PM)

ATTENDEES:

> Aneesh Chopra
> Carolyn Bagley
> John Dreyzehner, M.D.
> Carol Pugh, PharmD, MS
> Doug Gray
> Dave Austin
> John Kenyon
> Liza Steele

PRELIMINARIES:
1. Staff reminded the members present that the Chairman was unable to make this meeting.
2. Staff also indicated that the Website was operational and could be accessed for updates on Task Force information, valuable links to related Web sites and on each committee's activities.

AGENDA:

Review of the July 18 Teleconference Minutes
The July 18, 2005 Meeting Minutes were approved as amended.

Review of the August 2 Subcommittee Chair Meeting

Staff reviewed the main issues of the August 2, 2005 Teleconference:
➤ Concern expressed about progress being made. This forced a re-examination of the assumptions and questioning or restatement of the role of government in EHR:
  ❑ Bully Pulpit
  ❑ Payer
  ❑ Purchaser
  ❑ Infrastructure Creation
  ❑ Eliminating regulatory barriers
  ❑ Provider
➤ The State to take a lead in EHR using its role as payer of health care for State employees. The State could work with the two major health plans serving State employees to develop EHRs. The feasibility of this potential project is still being determined.
➤ It was recommended that the Task Force look at actions, which can be taken in the one to five year time frame.

Subcommittee Members then discussed the following EHR issues:

- *Provider Reimbursement*
  - One of the problems with EHR adoption is getting providers to buy in. They have to see the benefit in order to invest in EHR. One way to do this is to ensure that provider reimbursement rewards those that have implemented EHRs.
  - However, tying reimbursement to EHR utilization could negatively impact small providers who cannot afford EHR and may not even need EHR.
  - One estimate is that providers pay 80% of the cost of EHR, but receive only 20% of the benefit and any implementation has to take this into account.
- *State's Role in EHR*
  - It was suggested that the state could do this by assisting with the creation of infrastructure at regional levels by funding pilot projects.
  - The question arose as to why Virginia needed to spend tax dollars looking at health information infrastructure when this should be the federal government's role. In response, it was suggested that, Virginia wants to be in the lead technologically.
  - Subcommittee staff referred to a draft paper the Subcommittee Chairman had developed including a pilot approach which posited that the State needs to focus on providing funding for connecting the Commonwealth's systems (Medicaid, State employee insurers, VDH, etc.) with providers rather than trying to promote interaction between providers because of the competitive nature of our health care system.
  - One member indicated that, under this approach, providers that already have systems will get more funding and will get even further ahead and in effect, "the rich are going to get richer and the poor are going to get poorer".
  - However, another member indicated it made sense to focus on those that already have the EHR capacity because they were more likely to succeed. Allocation of the State's scarce resources should be based on 'capacity for success'. Once the State had a successful project underway, it would be easier to transfer that experience to others that were not as far along.

Conversation between Greg Walton and Chris Bailey
- Comparison of where each Subcommittee was in making progress to developing its report to the Task Force.
- The Virginia Hospital and Healthcare Association (VHHA) conducted a survey of hospitals' use of EHR and was surprised at how far along they were. This was in contrast to nursing homes, which were lagging behind hospitals in their use of EHR. It was pointed out that some health plans' use of EHR is very sophisticated and ties hospitals, insurers and patients together effectively.
- The Anthem project was discussed as an example of an insurer using reimbursement methodologies to provide incentives for hospitals to use EHR. Under this system, hospitals that make extensive use of EHR to manage prescriptions, records and quality and patient safety aspects are paid significantly more.

Potential Pilot Program Discussion
- There are three high-level proposals at present.
  - One possibility is to look at the use of the Emergency Room (ER) by low-income and uninsured individuals as a means to obtain primary care. It is believed that these services reduce inappropriate use of the ER, but there is not much data to prove that this is actually happening. EHR could help provide this data.
  - Another proposal is to promote linking physicians with the community clinics to share information more efficiently.
  - A question was asked about the criteria for judging proposals. The subcommittee chairman had proposed a list of criteria for the proposals. It was suggested and agreed that the criteria are intended to give the proposals more structure. It was asked whether the criteria for recommending project proposals would be consistent across subcommittees.
  - A related concern was raised with the selection of potential pilot projects: that it be done objectively and in a manner that avoids potential conflicts of interest.
  - Committee staff indicated they would seek guidance on both of these issues.
- One member expressed the desire that the subcommittee find out the "root causes" for physicians not adopting EHR. The subcommittee should have a comprehensive list of EHR problems and should prioritize these issues before making recommendations about pilot projects. The subcommittee needs to hear from providers directly in order to establish whether the slow adoption of EHR is due to high costs, bad marketing, or bad products.
- Discussion followed regarding the differences in practices and the need for providers in the field to determine what their individual needs are.
- Boston's New England EDI Health Network was mentioned as an example of what another state is doing. It is a system that allows health care information extraction from legacy systems. This capability does not involve a full EHR implementation but has value. It's secure and has no-cost access for providers, but hospitals and insurance companies do pay a sizable fees.
- Another member indicated that the health care regulatory environment was very different in Massachusetts and that this system might not be as appropriate in Virginia.
- One member indicated that the Task Force could learn from the decentralized approach that the federal government has taken on EHR. The Commonwealth also needs local solutions to see what works best.
- It was stated that in Virginia, 15% of providers already know that EHR is cost efficient within their own environments, even without interoperability with other systems. The State does not need to spend money on these providers since they are already convinced of the worth of EHR. However, it might be useful to get input from these providers about what works well and share this information with providers who have not implemented EHR.
- The goal of the state should be to increase the percentage of providers that use EHR, as well as to promote interoperability between providers that have EHR.
- There was consensus among the group that it would be good to hear from providers directly about their experiences with EHR. The following providers were mentioned as possibilities:

- ❑ Dr. Anton J. Kuzel, MD, and
- ❑ **C-Health** a practice with 2-4 providers that started with an electronic system and never had a paper system.
- ➢ One member indicated his impression was that claims denial rates were much higher in Medicaid than for other insurers. Thus, EHR efforts for the Medicaid population might result in significant savings. Subcommittee staff indicated that they would be able to supply the Medicaid denial rates for the next meeting.

Closing Issues

- ➢ Subcommittee staff provided the URL for the EHR website:
  http://www.ehealth.vi.virginia.gov/
- ➢ Subcommittee staff requested that subcommittee members review Version 1.1 of the Draft Subcommittee Report developed by the Subcommittee Chairman and start to think about what the final report should look like.
- ➢ The next meeting (teleconference) is scheduled for August 29 at 2:00 p.m.